May 11, 2021

The Honorable Xavier Becerra
Secretary
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Becerra:

The American College of Radiology (ACR), representing nearly 40,000 diagnostic radiologists, interventional radiologists, radiation oncologists, nuclear medicine physicians and medical physicists, appreciates the opportunity to submit our initial thoughts and input as the Departments of Health and Human Services (HHS), Labor and Treasury (the Departments) begin implementation of the No Surprises Act (NSA), included in the Consolidated Appropriations Act of 2021.

The ACR shares the goal of keeping patients out of the middle of billing disputes, while also addressing payer network adequacy issues that sometimes lead to "surprise medical billing" (SMB). It is worth noting that most of radiology is practiced in-network and that in the New York system, which has the longest experience with comprehensive surprise billing legislation, radiology accounted for less than one percent of all disputes.[1] The ACR believes that fair payment mechanisms are necessary to ensure adequate reimbursement for out-of-network services in order to support a sustainable healthcare system. By promoting good faith negotiations between payers and providers, and including mechanisms that promote network contracting, the NSA represents a reasonable solution to this issue. While the intent of the NSA is clear, to end surprise billing while preserving access to care, there are a number of policies in the Act that require further clarification through rulemaking. In this letter, we outline some of the ACR's main concerns that we hope will be addressed in rulemaking.

The Initial Payment

The ACR is concerned that since the initial payment is undefined, insurers have been given leeway that could be used as leverage to disrupt good-faith negotiations. For example, an insurer could indicate that they would initially reimburse at a fraction of Medicare and unnecessarily delay the negotiation and independent dispute resolution (IDR) process, potentially creating cash flow challenges for many medical practices. There is also concern that since the initial payment is not considered the health plan's final offer in IDR, plans could simply wait until the final offer is due to make a reasonable offer. This could be used to incentivize medical practices to accept unfavorable terms to be in-network, leading to practice instability or reduced services. Further, after an IDR determination there is a 90 days "cooling off period", where providers are prohibited from submitting a new claim for IDR with the same plan for the same service. The insurers could choose to again underpay during this 90 days' period, impacting cash flow of

medical practices. The ACR believes that systemic initial underpayment is an issue worthy of being monitored and reported to Congress.

The NSA indicates that an initial payment or a notice of denial is required within 30 days of the submission of the provider's initial claim. We ask that if an initial payment or a notice of denial is not received within 30 days, this should be deemed a de facto notice of denial.

The Qualifying Payment Amount

The "Qualifying Payment Amount" (QPA), as defined in the Act is initially benchmarked at the median contracted rate recognized by the plan or insurer in 2019 and then updated for inflation. The ACR requests that rulemaking clarify any potential ambiguity for future updates and ensure this formula is followed in subsequent years. This will limit insurers' ability to manipulate the QPA.

The ACR suggests that the Departments explicitly lay out the methodology for selecting the median. The QPA should reflect the total maximum amounts paid and be based on the total number of actual payments issued to individually contracted physicians in the same or similar given specialty as recognized by the carrier in the carrier's provider directory. When determining the total maximum amount that is used to set the median contracted rate, the calculation should include both the contracted rate for the Current Procedural Terminology (CPT®) code billed, as well as the pro-rata share of incentive or bonus payments.

In addition, the QPA needs to be based on the rate paid to the same type of providers in the area. It should be calculated as the median rate of all such providers that are in-network with a particular health plan in a region. Essentially, it is a weighted average of practice contracts. This is in contrast to the median of contracted rates at the group level. For example, if a health plan has three group contracts in a region, the QPA shouldn't default to the median rate of those three groups regardless of practice size. In addition, we request that the rule clarify that the QPA selected should be for the same item or service in dispute. Comparable items or services shall only be relied on when the QPA for the same item or service is unavailable.

Finally, the College believes that in order to set accurate median contracted amounts for distinct items and services, only data from comparable health plans should be included. Private health plans in the individual and small group markets are inherently different from commercial Medicaid managed care plans and therefore should be kept separate for the purposes of conducting these calculations. Keeping them separate also aligns with the statutory requirement that median contracted rates be tied to all plans offered by an insurer within the same insurance market. Medicaid managed care plans, Medicare Advantage, and private plans are in different insurance markets since they each serve distinct segments of the population.

Federal and State Law Interaction

There is a lack of clarity in the law about the various permutations that involve state-regulated plans, federally regulated plans and states with no out-of-network balance billing legislation, partial legislation and comprehensive legislation. Some states, like California and Florida, have a

payment standard but do not offer meaningful and accessible IDR. The ACR requests greater clarity on applicability of the NSA at the state level. For example, the College is concerned that vague or confusing state laws will fail to provide sufficient patient protections or a method for settling disputes, while prohibiting access to federal protections, such as meaningful access to IDR.

The intent of the NSA was to provide clear protections for patients and to ensure that there is a balanced method of resolving reimbursement issues between plans and providers for all non-contracted services. If a state law does not govern all non-contracted services but the state law is allowed to preempt federal provisions for all services, the outcome would be a direct contradiction to the intent of the NSA and result in a misappropriation of the statutory provisions. We request that reasonable access to IDR, at least as accessible as in the NSA, be available nationally.

Independent Dispute Resolution

The criteria for IDR, as detailed in the No Surprises Act, do not indicate that any factor should be given preferential weight. The College is concerned that if the QPA is recognized as the primary factor in IDR, the Act will be become in essence a benchmark law around the median in-network rate. Such an approach was considered but ultimately rejected by Congress. The intent of the NSA is to protect patients by ending the issue of surprise medical billing while preserving access to care through good faith negotiations between providers and insurance companies. Establishing a benchmark, either directly or by designating the QPA as the primary factor among the arbitration criteria, would disrupt such good faith negotiations.

Unless specifically excluded by statue from consideration in IDR, the parties should be permitted to submit additional data. As an example, past IDR determinations should be considered in subsequent IDR determinations and parties should have the right to submit and discuss such past determinations.

After a determination in IDR, the NSA requires the non-prevailing party to settle the reimbursement difference with the prevailing party within 30 days. Failure to comply within the time period should result in the addition of interest charges, using an existing HHS mechanism for overdue debts.

The College would also like to acknowledge the importance of other arbitration criteria specified in the Act, including previously contracted rate and attempts (or lack thereof) to contract. Such criteria encourage network contracting and promote broader access to care.

Efficiency: Labeling and Batching

To improve efficiency of the system, as well as improve transparency, insurers should be required to clearly delineate on the patient's insurance card and in the ANSI 835 remittance advice that the plan is ERISA, Medicaid Managed Care Organization, grandfathered Affordable Care Act (ACA) plan, ACA plan, Medicare Managed Care, group, individual or otherwise. Such labeling will help eliminate incorrect procedures and limit wasteful spending.

The Act gives the HHS Secretary the authority to "specify criteria under which multiple qualified IDR dispute items and services are permitted to be considered jointly as part of a single determination by an entity." The statute goes on to state that it can only be applied to items and services "furnished by the same provider or facility". In this sense, "provider" could be either the group practice or the individual physician. The ACR believes that the requirement to batch claims for IDR at the clinician (e.g. individual national provider identifier (NPI)) level may create barriers to access and waste. Two physicians in the same practice, billing the same health plan, even on the same day and for the same service for the same indication should be allowed to batch their claims. This is analogous to other Medicare programs, such as the Quality Payment Program, which supports Group reporting for individual providers working under a group tax ID number (TIN). Batching of claims supports an efficient IDR process. Congress clearly considered these efficiencies when it permitted batching for 30 days of claims for the same or similar services. Thus, the ACR suggests that the Secretary should create regulations that implement a definition of providers that reflects the statutory language as well as real-world claims processing practices. This should allow batching for providers in the same TIN, billing the same health plan for the same service for the same or similar indication within a 30-day period.

Thank you for the opportunity to provide initial feedback. The ACR looks forward to continuing to engage and offer comments during the rulemaking process. If you have any questions, please contact Kathryn Keysor, ACR Senior Director, Economics and Health Policy at kkeysor@acr.org.

Sincerely,

DocuSigned by:
William Thorwarth
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William T. Thorwarth, Jr, MD, FACR
Chief Executive Officer

[1]New York State Department of Financial Services: https://www.dfs.ny.gov/system/files/documents/2019/09/dfs_oon_idr.pdf